Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST
PO BOX 89008
HOUSTON TX 77289

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-2389-01

MFDR Date Received
MARCH 19, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has paid partial payments on the remaining two open dates of service. They refuse to pay any additional amounts even with several different attempts on HealthTrust's part. HealthTrust sent in an original reconsideration letter in on November 28, 2011. This reconsideration letter had 12 dates of service that needed payment. Gallagher Bassett decided to pay some dates of service and not others. All 12 dates listed were with the exact same procedure code and had 8 units, except 1 date only had 7 units. HealthTrust sent in an additional reconsideration letter requesting payment on the 2 remaining dates of service along with the original initial interview. Gallagher Bassett paid for the initial interview but denied the other 2 dates of service because 'additional information' was required. This is completely aburd [sic] because 18 of the 20 approved sessions had been paid in full with the exact same amount of medical documentation. This reconsideration was denied out because of a 'billing/submission error', so HealthTrust then in turn resubmitted an additional reconsideration letter on January 27, 2012 correcting this issue. After this reconsideration letter, HealthTrust received a partial payment for one date of service and no additional amount on the other date of service…"

Amount in Dispute: $2,020.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary as stated on page one of the DWC-60: "DOS 10/7/11 paid on 3/8/12 DOS 9/1/11 will be escalated for another review by bill review."

Response Submitted by: Donna Smith, PO Box 23812, Tucson, AZ 85734

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2011 October 7, 2011	Chronic Pain Management Program	$2,020.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the reimbursement guidelines for Workers' Compensation Specific Services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – (W1) Workers Compensation state fee schedule adjustment
   - 12 – (125) Submission/billing error(s)
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments.
   - 16 – (16) – Claim/service lacks information which is needed for adjudication.

Findings

1. According to the respondents position summary date of service October 7, 2011 was paid on March 8, 2012 and date of service September 1, 2011 was to be escalated for another review by bill review. On March 13, 2013 a call was place to Donna Smith; it was found that Donna Smith was no longer with Gallagher Bassett, TPA for Indemnity Insurance Co. I was forwarded to Kimberly Vanderbilt and left a detailed message asking for proof of payment; however, a return telephone call was not received. Therefore, the disputed dates of service will be reviewed in accordance with applicable Division rules and the statute.

   CPT Code 97799-CP for date of service September 1, 2011: On October 26, 2011 Gallagher Bassett used payment exception code W1 – "(W1) Workers Compensation State Fee Schedule adjustment" and issued payment of $700.00; the requestor submitted the bill for reconsideration and on January 18, 2012 Gallagher Bassett denied additional payment using denial code 12 – "(125) Submission/billing error(s)". According to the requestors position summary HealthTrust "resubmitted an additional reconsideration letter on January 27, 2012 correcting this issue." On March 5, 2012 Gallagher Bassett re-audited the medical bill and used explanation code W1 – "(W1) Workers Compensation State Fee Schedule Adjustment" and BL – "This bill is a reconsideration of a previously reviewed bill. Allowance amounts do not reflect previous payments." The respondent did not maintain the previous denial; however, no allowance was recommended. Per 28 Texas Administrative Code §134.204(h)(1)(B) and (h)(5)(B) reimbursement shall be $125 per hour if the program is CARF accredited. Since HealthTrust did not bill the –CA modifier payment shall be 80 percent of the MAR which is calculated to be $100.00 per hour. The requestor billed 8 units of CPT Code 97700-CP and was reimbursed $700.00. In accordance with 28 Texas Administrative Code §133.307(2)(E) the request shall include a copy of all applicable medical records specific to the date of service in dispute. Review of the submitted documentation finds that the requestor did not submit copies of any medical records. No documentation was found to support the services were rendered as billed. As a result the amount ordered is $0.00.

   CPT Code 97799-CP for date of service October 7, 2011: November 15, 2011 Gallagher Bassett denied the services using denial code 16 – "(16) Claim/service lacks information which is needed for adjudication." The requestor submitted the bill for reconsideration and on January 18, 2012 Gallagher Basset denied the services using denial code 12 – (125) Submission/billing error(s)." According to the requestors position summary HealthTrust "resubmitted an additional reconsideration letter on January 27, 2012 correcting this issue." Gallagher Bassett re-audited the bill on March 8, 2012 and used explanation code W1 – "(W1) – Workers Compensation State Fee Schedule Adjustment" and issued payment in the amount of $400.00. Per 28 Texas Administrative Code §134.204(h)(1)(B) and (h)(5)(B) reimbursement shall be $125 per hour if the program is CARF accredited. Since HealthTrust did not bill the –CA modifier payment shall be 80 percent of the MAR which is calculated to be $100.00 per hour. In accordance with 28 Texas Administrative Code §133.307(2)(E) the request shall include a copy of all applicable medical records specific to the date of service in dispute. Review of the submitted documentation finds that the requestor did not submit copies of any medical records. No documentation was found to support the services were rendered as billed. As a result the amount ordered is $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		March 18, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.